Massage Therapy Health History Form

For your information:

An accurate health history is important to ensure that it is safe for you to receive massage treatment. If your health status changes in the future, please let us know. All the information gathered for this treatment is confidential except as required or allowed by la or except to facilitate diagnosis or treatment. You will be asked to provide written authorization for release of any information.

Personal History

Name:_____Date: _____

Address:_____Postal code:_____

Tel: Res._____Tel: Bus. _____Tel: Cell_____Email:_____

Date of Birth: _____Occupation: _____

Name and phone number of emergency contact: _____

What is your primary complaint? _____

General health_____

How did you hear about us?.....

Health history: Please indicate conditions you are experiencing, or have experienced

Respiratory

- ❑ Chronic cough
- ❑ Shortness of breath
- ❑ Bronchitis
- ❑ Asthma
- ❑ Emphysema
- ❑ Sinus infection
- ❑ Family History of any above

Cardiovascular

- ❑ High Blood pressure
- ❑ Low Blood pressure
- ❑ CCHF
- ❑ Heart attack/MI
- ❑ Varicose veins
- ❑ Phlebitis
- ❑ Stroke/CVA
- ❑ Pacemaker or similar device
- ❑ Family History of any above

Infection

- ❑ Hepatitis
- ❑ TB
- ❑ HIV
- ❑ Infectious skin conditions
- ❑ Herpes

Other conditions

- ❑ Loss of sensation
- ❑ Diabetes (onset:_____)
- ❑ Allergies (i.e. anaphylaxis or skin irritation
- ❑ Epilepsy
- ❑ Arthritis
- ❑ Family history of arthritis
- ❑ Cancer
- ❑ Fibromyalgia
- ❑ Urinary disorders
- ❑ Kidney disorders
- ❑ Digestive disorders
- ❑ Liver
- ❑ Hernia
- ❑ Osteoporosis
- ❑ Skin conditions_____
- ❑ Headache
- ❑ Migraines

Head/neck

- ❑ Vision problems
- ❑ Vision loss
- ❑ Ear problems/pain
- ❑ Hearing loss

Women

- ❑ Pregnant (due: _____)
- ❑ Gynecological conditions
- ❑ Menopause

Soft tissue/joint discomfort and its nature (pain/stiffness)

Head _____

Neck _____

Low back _____

Mid back _____

Upper back _____

Shoulders L R _____

Arms L R _____

Legs L R _____

Knees L R _____

Other _____

Current Medication _____

_____

Condition it treats _____

Surgery _____ Date _____

Nature_____

Injury _____Date _____

Nature _____

Primary physician _____

Address _____

_____

Present involvement in other care ☐ **Yes** ☐ **No**

If "Yes" please specify:_____

_____

Have you had Massage Therapy Before? ☐ **Yes** ☐ **No**

If "Yes" please specify how long ago: _____

Other medical conditions (e.g. mood disorders, sleep disorders, hemophilia, etc.) _____

_____

Of special note: (presence of internal pins, wires, artificial joints, special equipment) _____

_____

To the best of my knowledge I certify that the information provided above is correct and true.

Sign---------- Date----------